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Periodontics & Implants

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HEALTH QUESTIONNAIRE-PLEASE CIRCLE YES OR NO WHERE INDICATED

Current Date _____ Patient name _____

Primary Care Physician: _____ Physicians phone: _____

YES NO: Do you require antibiotics prior to treatment? {I.E. heart stents, hip/knee replacement} If yes, please provide reason: _____

YES NO: In the last ***two to five years***, have you been hospitalized? briefly explain: _____
YES NO: Has your general health recently changed in the last two years? Briefly explain: _____
YES NO: Do you smoke cigarettes?
YES NO: Do you use electronic smoking devices?
YES NO: Have you ever been treated for Periodontal Disease? in what year? _____
YES NO: Do you currently take blood thinners? name of the medication: _____
YES NO: Have you ever had trouble associated with a dental procedure? please explain: _____
YES NO: Have you ever been checked for diabetes?
YES NO: Do you currently require insulin?

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS LISTED?

YES NO: HIV---*OR*---AIDS	**YES NO:** SINUS TROUBLE	**YES NO:** HIGH BLOOD PRESSURE
YES NO: VENEREAL DISEASE	**YES NO:** SEIZURES---*OR*---CONVULSIONS	**YES NO:** ASTHMA
YES NO: PACEMAKER	**YES NO:** PROSTATE DISORDER	**YES NO:** GLAUCOMA
YES NO: HEART MURMUR	**YES NO:** COLD SORES---*OR*---FEVER BLISTERS	**YES NO:** TUBERCULOSIS
YES NO: STENTS	**YES NO:** OSTEOPOROSIS	**YES NO:** MITRAL VALVE PROLAPSE
YES NO: DIABETES/ 1 or 2	**YES NO:** COMPROMISED LIVER	**YES NO:** STROKE---*OR*---HEART ATTACK
YES NO: HEPATITIS/ A or B or C	**YES NO:** RHEUMATIC FEVER	**YES NO:** HEART DISEASE
YES NO: JAUNDICE	**YES NO:** VERTIGO	**YES NO:** ARRHYTHMIA
YES NO: SLEEP APNEA	**YES NO:** CHEMOTHERAPY---*OR*---RADIATION TREATMENT	

Other condition(s) not listed: _____

ARE YOU ALLERGIC TO ANY OF THE MEDICATIONS BELOW? (EXAMPLE OF AN ALLERGIC REACTION: ANAPHYLACTIC SHOCK)
(IF YOU ARE ALLERGIC-CIRCLE YES, IF NOT ALLERGIC- CIRCLE NO, IF YOU DO NOT PREFER IT-CIRCLE DON'T PREFER)

YES	**NO**	**DON'T PREFER:**	LOCAL ANESTHETICS	**YES**	**NO**	**DON'T PREFER:**	PENICILLIN
YES	**NO**	**DON'T PREFER:**	SULPHA DRUGS	**YES**	**NO**	**DON'T PREFER:**	AMOXICILLIN
YES	**NO**	**DON'T PREFER:**	DOXYCYCLINE	**YES**	**NO**	**DON'T PREFER:**	ASPIRIN
YES	**NO**	**DON'T PREFER:**	CLINDAMYCIN	**YES**	**NO**	**DON'T PREFER:**	LATEX
YES	**NO**	**DON'T PREFER:**	NARCOTICS (pain killers)	**YES**	**NO**	**DON'T PREFER:**	CODEINE
YES	**NO**	**DON'T PREFER:**	IBUPROFEN	**YES**	**NO**	**DON'T PREFER:**	TYLENOL
YES	**NO**	**DON'T PREFER:**	VALIUM	**YES**	**NO**	**DON'T PREFER:**	TRAMADOL

Please explain your allergic reaction: _____

Allergic to other medication(s) not listed: _____

PLEASE PROVIDE A COPY **OR** LIST BELOW ALL **PRESCRIPTION/OVER THE COUNTER MEDICATION(S), VITAMIN(S) ETC. YOU CURRENTLY TAKE:**

_____ _____ _____ _____

_____ _____ _____ _____

PLEASE CIRCLE RESPONSEFOR WOMEN ONLY**FOR WOMEN ONLY **FOR WOMEN ONLY******************
YES NO: Are you currently taking oral contraceptives (birth control)? If yes, provide name of product: _____
YES NO: Are you on Hormone Therapy? If yes, provide name of product: _____
YES NO: Are you pregnant?
Are you **POST** or **CURRENTLY EXPERIENCING** menopause? **(CIRCLE RESPONSE)**

Signature of patient **(or parental/guardian):** _____

Printed name of patient **(or parental/guardian):** _____
Printed name not required here, if same as on top of page)